Saidkhodjaeva, Lola 2021

Lola Saidkhodjaeva Oral History

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Lola Saidkhodjaeva

Behind the Mask

February 22, 2021

Barr: Good morning. Today is February 22nd, 2021 and I have the pleasure of speaking with Ms. Lola Saidkhodjaeva, RN (BSN), CMSRN. Lola is a Research Nurse Specialist with the National Institute of Child Health and Human Development (NICHD). During the COVID-19 pandemic that affected so many cities within the United States (US), she volunteered for and was approved by the NICHD leadership to deploy with the US Public Health Service to the underserved Native American region of Shiprock, New Mexico to provide aid to the Navajo Nation. Today, she is going to talk a little bit about her experiences during her deployment.

Lola, thank you very much for being with me. How did you decide to volunteer to assist the Public Health Service with the Navajo Nation in New Mexico? That sounds like it was such an interesting opportunity.

Saidkhodjaeva: Yes. As the pandemic spread throughout the US, our NICHD admissions decreased, and so did the number of patients we were admitting to our research protocols. The HHS leadership put out an email calling for civil servant volunteers to deploy alongside United States Public Health [Service] officers in certain underserved regions throughout the US. When that call to service came out, I volunteered to deploy to provide nursing care to an area of need. Of course, I had to ask permission from my supervisors . I was deployed with a USPHS strike team at the Navajo reservation in Shiprock, New Mexico. I wanted to deploy somewhere that was considered a hotspot so that I would be able to make the most impact as a nurse. That's how it started.

Barr: Do they assign you a place or do you have a choice? Can you ask to be at certain locations?

Saidkhodjaeva: Originally, when I applied to be a volunteer, they offered me Washington, D.C. but I responded that I wanted somewhere that was a hotspot. D.C. was not at that time. They then assigned me to the team deploying to New Mexico. Although I didn't choose that assignment specifically, I researched and found that there was a great need for healthcare providers there so I was pleased with the assignment. My notification was last-minute. The logistics coordinator notified me on Saturday morning that I was supposed to be on a flight on Sunday.

It was kind of awkward because I had asked my supervisor for permission when I first applied, but it was passive request and approval because I didn't know if I was definitely going to do it or even if the PHS was going to offer me a deployment option. So, I found myself on Saturday morning scrambling to get permission from my first-level and second-level supervisors. Being that it was Saturday; I wasn't sure how I would be able to reach both supervisors, much less get both approvals short-notice. I had to page one of my supervisors and sent emails to both. They were so wonderful because they both responded immediately. Then next thing you know, I was on the plane on Sunday morning.

Barr: Wow. That's unbelievable. When was this, in March or April?

Saidkhodjaeva: It was in May. I got deployed from May 9th until June 9th.

Barr: What training and preparations did you have to undergo before you could begin working with patients?

Saidkhodjaeva: We didn't have any training before here in Maryland because it was a last-minute thing, but there, we had training about the PPE [personal protective equipment] and how we don and doff, and then the proper procedures. Our original mission was to help the hospital in the sense of opening an alternative care site in the gym for overflow patients. They were all going to be low acuity COVID positive patients; the ones that don't require a lot of care and that can ambulate by themselves. The criteria were their oxygen was supposed to be above a certain level; they couldn't be on high flow and things like that. All the training was provided for us originally to open a site, which was a little bit different from the hospital, but then the mission changed. Although our primary mission remained staffing the overflow facility, we were placed in the COVID unit of the hospital because there were not enough patients who met the criteria to open the overflow facility. We had to undergo some additional hospital-based training when the mission changed. I mean they overlap, but in the hospital, they have their own policy and procedures.

Barr: How easy was it to learn the policies and procedures of the hospital that you were working at as you were going? That seems like that would be challenging.

Saidkhodjaeva: Every hospital is different in their policy and procedures, but in the main the umbrella of all of them have the same concept, and since I already worked in a hospital before my position, I did the bedside nursing. It was kind of familiar. There was just a little bit of tweaks to find out, plus the policy and procedure always evolved because COVID at that time was completely new, it was just starting up so things would change. There were periodic changes to policies, but we adapted. It required a lot of flexibility, but everyone had to do it. It was new for everyone, so we just rolled with whatever changes in policies or procedures were implemented.

Barr: That's great. Did you learn anything about the Navajo people at all before you started to work with them?

Saidkhodjaeva: Yes. I had to take cultural training and competency as a part of our orientation. An example was learning how (the Navajo) perceive a hospital stay and death. For example, one of the main challenges we could not open up. They were saying we can only take low acuity [patients not at risk of death] in the alternative care side because of the way the Navajo Nation perceives death. If someone dies at a specific place, they cannot use it anymore. Since it was a school gym that was converted into a 100+ bed facility, the local cultural educators explained that if someone died in the facility, then kids won't be able to ever go back to that school. That was their perception of the potential effect of allowing. The Navajo are very spiritual in how they view certain things. For example, it was explained to us that they can't have certain things on one arm or there are certain ways they communicate. They don't always look in your eyes, but it's not because they're disrespecting you. It's just because of their culture. Yes, we had that training, and we did experience those cultural norms. It was helpful because it made me approach my patients differently.

Barr: Absolutely. What are some reasons that those who are a part of the Navajo Nation have had a particularly difficult time dealing with COVID?

Saidkhodjaeva: Actually, I was really surprised when I was there. I was kind of isolated from the news because of the extended hours and need to rest after each shift. For my role, I worked 12-hours on the COVID unit, with a 30-minute shift report and an hour commute to and from the reservation. The days were long, so it was only from friends that I learned that CNN reported that the Navajo reservation at Shiprock had suppressed the number of cases per capita when compared with New York. That was surprising too because I thought that New York was the hottest spot at that point. But then we learned about some of the contributing factors were such as houses with large families and multigenerational households that didn't have electricity and/or running water. I learned from the local staff that a lot of families had small single level houses with what I heard could be up to 10 people in one household, not like houses where a family of four might have town house or a private multilevel home. When I spoke with patients, I learned that not all of them have a means of transportation and then they had to get to a hospital. It was not always really close. That I think made it even more difficult. They wouldn't be able to isolate. Let's say one family member got sick: if they live in a really small house, then there is no possibility of complete isolation, so it was a cycle that could eventually get everyone in the household sick. Of course, regarding the hand washing—which is important—if you don't have running water, it's really hard to constantly wash your hands.

Barr: Oh. Goodness.

Saidkhodjaeva: They did try to implement measurements to slow or stop the spread on the Reservation. They have a really strict curfew which started at 8 pm and ended at 5 am every Monday through Friday. On the weekend, it would start on Friday at 8 p.m. and it will end on Monday at 5: 00 a.m. Then to be out on the Reservation after the curfew, we had to have special permission; we had to have paperwork in case we get stopped by the police saying that we [were] traveling to the hospital, that's why we're on the road because we [couldn't] leave. We couldn't live on the Navajo reservation, so our hotel was about 45 to 60 minutes from the hospital.

Barr: About how many people did you work with? Fellow volunteers?

Saidkhodjaeva: I think there was a total of 50 people. But, only two of us, only me and another person who was a volunteer paramedic, [were] civilians and volunteers. The job of the USPHS [U.S. Public Health Service] is to deploy in the case of an emergency, so I believe they were assigned the deployment. They [the PHS officers] had varying job descriptions. There were social workers and a lot of administrative people. But I think there were about 20 out of the 50 that were actual healthcare professionals. Of those, I believe that only 15 were actively credentialled to work with the patients.

Barr: Can you describe in detail your experience with the Navajo Nation including how you contributed to caring for COVID patients? Also, what were some of your other assigned duties?

Saidkhodjaeva: Yes. The mission in the beginning was to take care of COVID patients, but less acute patients. Then, the mission changed to support the nursing staff on the COVID unit, and some clinicians and case workers supported the hospital in their own disciplines. The unit that I and my fellow nurses were working was completely dedicated to COVID patients. It was originally a med surg unit that was converted to dedicated COVID unit . Anyone with varying degrees of acuity was there so we had to adapt the way of caring for the patients. Of course, my other duties besides taking care of COVID patients by administering a wide array of medications and treatment plans—at some point we also were still preparing to open that alternative care site, which was a new experience for me. One new role was writing policies, specifically nursing policy. I haven't done that before, so it was really an interesting experience. I know how they [general policies] work, but it was for the alternative care site so we had to think about issues or alternatives that wouldn't have to think about at the hospital. For example, they [the hospital] has a code-team to respond to anyone in cardiac arrest or other emergency in the hospital. In the hospital, the code team is paged, and they come, but this was not the case in the alternate care site. We had to think about the policy to develop and create a team. But we didn't have a lot of staff, so we had to implement dual roles for staff to include taking care of patients while also serving on the team in case of emergencies.

Barr: That is so interesting. How long was a typical shift and how did you divide your duties? Was it mostly caring for patients and then some help with alternative care? How was that divided?

Saidkhodjaeva: The shift was long because it was about 12-and-a-half-hour for each shift. I was assigned to the night shift, which is not my favorite. And the commute was about an hour each way, so about a 14 ½ hour days. Because it was a state of emergency and we were there for a short period of time, we were working 12 hour shifts with an additional 30 minutes for patient reports, six days on and one day off. It's really intense, especially for the nurses, because nurses usually work three 12-hour shifts in a week. We had to do six 12-hour shifts in a week.

Then sometimes if we knew we're approaching the ability to open the alternative care site (ACS), some of us had to work a shift at the hospital while also working on policies and procedures or training for the possible opening of the ACS. But the majority of the time was spent on the COVID hospital unit and we would have assignments as we would on any regular nursing unit. Then you just carry through with those patients through-out your shift. But of course, things changed. During nighttime, we were getting a pretty good number of admissions because they were coming from the emergency department or for example, they were not able to get there early and then someone drove them after work. They'll drive them and then the ER would have to do certain number of tests and to confirm COVID. Then they'll transfer to us.

Barr: How many patients would you get on average per day? That you were responsible for?

Saidkhodjaeva: Between two and four. It of course depended on different variables. You might start with two and when admissions were all over by the end of your shift, you end up with four. And, of course it will also depend on acuity. The managers and nurses were trying to spread it out to be an even assignment. Sometimes if you have two patients it seems like it's not a lot, but then they're really acutely ill. They are occupying the whole night. You're trying to run back and forth and between rooms and things like that.

Barr: What was the turnaround in terms of releasing patients? Did you have a lot of patients that stayed for a very long time in the hospital?

Saidkhodjaeva: Yes, usually it was about two weeks, but it also depended on how they felt. By the time they get to us, they might have already had COVID for the past seven days. Then their admission will usually shorten by seven-day period. Another reason they wanted to have an alternative care site is because some patients who were not critically ill and were able to go home, but they were saying that they cannot because they will live with so many people and they are the only one infected and they have nowhere to go. One of my patients explained to me that she, " will end up having to sleep in the car," and that was hard to hear, you know, because especially coming from NIH. NIH is a wonderful facility and we have many concurrent clinical research patients, but we never have to worry about extending a patient's admission. But if there are not enough beds on the COVID unit, some lower acuity patients had to be discharged to make room for those in more emergent need of care. Of course, they had wonderful social workers working with them. I'll say between a week to two weeks.

A lot also depended on the changing status of each patient, whether they were getting better and recovering or some might need more advanced care. If a patient worsened, there were certain criteria for them to be transferred to ICU but the hospital actually had a wonderful system, which I was impressed by. Everyone was on frequent oxygen saturation checked and if it fell below a certain level, they were hooked up to the vitals and cardiac monitor on our floor, but the ICU staff also had access to the same monitors screens that we did, so they were able to monitor our patients from the ICU. If they noticed abnormal vitals, they would also be able to notify us if they believed the patient should be transferred to the critical care unit. In some cases, the patient might have needed to be intubated, but the ability to share the monitor screens helped expedite the process. When it was necessary, the doctor would come and assess the patient and immediately transfer the deteriorating patient to the ICU. However, the ICU was really small so it couldn't hold the patient for a long time. As soon as they got intubated and were stabilized, they usually got transferred to another larger hospital because the Navajo hospital was a relatively small facility. So honestly, even though I was working three days in a row, the patients changed all the time. It was rare that I'll ever get the same patient. I see one is gone and one is already here. It all depended about the turnaround time.

Barr: You have talked about this alternative care site that you are helping with. What sort of services was this site providing?

Saidkhodjaeva: While I was there it never opened, but the whole purpose was to have the overflow patients who are COVID positive and who are stable to kind of help them finish their quarantine and finish their recovery. The plan was that these patients would get their medications there and be monitored. It was actually the gym at the high school on the reservation, and FEMA engineers separators to create individual small patient rooms. Each small room (actually a small cubicle) had a bed, there was oxygen, there was a sink in the hallway, and each cubicle had a chair. It was a really simple kind of a shelter in place situation. So their services would be basic patient care assuming they're able to ambulate by themselves. Meaning, they could care for themselves, go to the bathroom on their own, and do the basic things for themselves. But of course, we would have administered medications if they were on oxygen or needed minimal medical assistance.

Barr: How did the way that you approached and treated cases evolved over the course of the time you were there? You saw so many patients and in May a lot of things came about COVID.

Saidkhodjaeva: At that time it was still new, the COVID thing, and they didn't have a lot of treatment readily available. It was mostly managing the symptoms and maintaining basic needs and to make sure that they kind of go through that disease without major complications. But of course as I was telling you, the policy always changed, such as how we used PPEs or how we redistributed patients for example. For me, this was a really new zone, a new concept, about the infection control and prevention. On the unit, everyone was COVID positive, so every room was considered a hot zone. Then, there's a nursing staging area that was the warm zone (nurses still wore PPEs, but not gowns or faceshields) and only when you come off the unit, there was the cold zone (where only masks were necessary). They were always changing the policy, where you wear a certain PPE, what you do, how do you gown, and things like that. But I did have a chance to administer an experimental agent which was Remdesivir in infusion. Now it's actually approved by the FDA for the COVID treatment for patients who are at the hospitals.

Barr: That's very interesting. What were some of the challenges you faced? You already spoke about a few of them as well as some of the opportunities in treating the patients?

Saidkhodjaeva: I think the biggest challenge for me was seeing people die, especially the elderly and then be present as their relatives were present and watched their loved one deteriorate and eventually succumb to the disease. We had some family members admitted together as I was saying. They live close by so when the patient was admitted a lot of them will come with the family. In one particular case, we had a mom and a daughter as patients in the same room and then the daughter had to observe how her mom was intubated and then transferred to ICU. As loved ones saw their relatives die, that was really hard for me.

The shift was long, wearing the N95 and a surgical mask together was really hard to breathe, it's really hard on your skin. I had skin breakdowns by the mask. It was mentally, physically, and emotionally challenging. And the opportunities? I was just really grateful that I was able to make a contribution during this pandemic because I felt really strongly about helping my fellow nurses. I went into the nursing profession because I wanted to help people and then while this happened, I couldn't just see—I was mostly teleworking. I knew I was making a difference with my patients, but I felt for all the frontline workers, all fellow nurses, and doctors. So I was able to help and feel I accomplished something during the pandemic. That was wonderful. Like administering experimental medication, now they're approved, I'm like that's wonderful I was able to do that.

Barr: How did you comfort some of those families? That had to be really sad.

Saidkhodjaeva: It was really hard especially because a lot of people were not able to see their loved ones in the hospital because only patients were allowed in the hospital. In the usual situation what happens is you get the palliative care and then the family comes to say goodbye, but they couldn't do this for all patients who were admitted for COVID and some died without loved ones present. One of the things we were able to do is like, for example, we let the family members come to the window so they can say their goodbyes, or they would give some posters that their loved one could see or give something that they can hold on to. But it was really hard because I didn't deal with a lot of death when I was doing the bedside nursing because of my patient population. It was really hard to overcome seeing that and how it affects the family members because they feel like they're helpless. They cannot do a lot while this was happening.

Barr: What were the demographics of a majority of your patients? Were they mostly older people or a mix of ages?

Saidkhodjaeva: It was actually a mix of everything, but I've seen most of the patients who died were the elderly ones, but they were between 20 years to all the way to 95. It was really a variety of ages.

Barr: What is something that you felt like you took away from your experience that has made you a better health care provider at NIH?

Saidkhodjaeva: I was thinking about it and it's like I grew up at NIH in my nursing career. I joined NIH in 2011 as an intern and then I went to nursing. I did various jobs at NIH, but I grew up around the research. NIH is a wonderful facility, but it's so different from the outside because everything is really controlled to make sure that the research runs smoothly and that you can prove that your treatment and things work. I never had opportunity to be in outside nursing for a long period of time. For me, this deployment was exposure to new paradigm of nursing. We were literally setting up triage in the parking lot and trying to do intubate patients in the ER.

Now I have this experience to respond to public emergency, which is wonderful. And of course, it gives me a lot of confidence in my skills and my ability. It helped me to understand that there should always be flexibility. Things change but it does not mean that things are going to get worse. It means they're going to get better the more things evolve. It really helped me. Now I feel really confident that if something else happens, I won't have any problem deploying again. In the beginning stages when COVID happened, everyone was really scared. I was scared for my family, but the more I did it I find that it is manageable. We can do it if everyone puts their efforts to helping everyone no matter one's capacity, we can get over that.

Barr: That's amazing. How did you keep giving a hundred percent of yourself under such trying circumstances?

Saidkhodjaeva: It was definitely challenging, but everyone was going through it. I mean with people I work with, people who are assigned to the night shift were kind of close because we had to commute together in the groups and then we had meetings together. We were each other's support. We knew what everyone is going through, and everyone was going through this. Then it was really encouraging each other. They were checking, "Hey how are you feeling? Do you need some break? Let me take care of your patient. You go drink some water." Things like that. And then knowing about my friends and my loved ones that they were really supportive. They were sending me messages every day.

I think the huge one for me was knowing that I make a difference. I knew what the goal is, and I knew whatever I had to do. I mean it's hard. You know I want to say that the actual heroes were the people who actually worked there all the time because yes, we came and helped, and it was wonderful. But they're the ones always having to hold that front, and if I can at least help them a little bit to relieve their daily routine or how they cope with this, then I knew that was actually making the difference. I was helping them, and I can be strong for them. Then when I come home, I can rest. I knew for me it was a short period of time. It was not as difficult as for them. I wanted to make sure I am able to support them in any way I can.

Barr: How has COVID affected how you perform your job at NIH?

Saidkhodjaeva: Yes, a lot of changes. We used to spend about 40 to 50 hours a week in the offices, physically being there, and now it's mostly remote work. We still communicate with the patient. We still do a lot of things, but it's not more face-to-face physical. I mean we had to learn telemedicine. I knew it was around, but it was not used where I worked. Now it's a lot of communication over the phone and over Microsoft Teams or things like that. We had to change our policy in the way we see patients, the way we do that, the way we consent. It was a lot of changes. I think some of them are for the better, especially telemedicine. It's so much easier to talk to people who are even in different country. As you know we deal with rare diseases and it's often that we have to bring patients from overseas and now we cannot do this but at least we can counsel them. We can give them advice. I think a lot of changes were for the good. I don't think my productivity decreased. I actually think it increased. Sometimes it feels like you don't leave work, but it also feels like you have more flexibility in doing your job.

Barr: That's true. One of my last questions, this is a fun question. What is a lasting memory that you will always have from your deployment? If you could pick just one?

Saidkhodjaeva: It's hard because there's so many. I was really memorable for me, you know. For me, I never worked in an emergency department. They had a rotating shift there and how welcoming they were there. What I want to say is how much they trust us. They didn't know us, the people who worked at the hospital. But they were really trusting and allowed us to do a lot of things. I remember one day we were working at the emergency department, and the triage was set up at the parking lot because you had to screen if they had COVID or not. Then one night it was I think 2:30 a.m. in the morning there were three large official-looking vans and sedans pulled up to the parking lot triage area. I wondered if were in trouble or did something happen? And then they had some juvenile detainees come out of the vehicles and the guards explained that they needed medical evaluation because they all drank alcohol from hand sanitizers." It was really for me an interesting experience because I never took care of any people who were detained by law enforcement and then just how it was set up. I just remember this, and the kids were really funny. It was just that it was a warming experience for me.

Barr: Did you get to do any sightseeing when you were in the area like just looking at the landscapes or anything?

Saidkhodjaeva: I mean we barely had any time. But one time we were at the Shiprock. The name came from some mountain. I sent you a picture, which actually when you come in a specific time, it looks like a ship. One time we went after our night shift when we knew we had the next day off, and we went to look at it. Otherwise, we didn't have a lot of time to do anything because how hectic the schedule was. But while we were driving to the hospital, of course, we saw their beautiful scenery. Actually, one day we all had a day off on the same day, and we went to one of the mountains. Then we walked around there. But that is about it.

Barr: Wow. What an incredible experience. Is there anything else that you would like to add about your experience with the Navajo Nation but also as a clinician at NIH and a person living through the pandemic yourself.

Saidkhodjaeva: I just want to add how wonderful the Navajo Nation is. They were so grateful to us. They trusted us so much—because we were also strangers—and they were just really thankful. They always said thanks to us. They never complain, even like people who are in the worst shape. I knew they were in pain and I'm like, "Hey do you want me to bring your stuff? Do you want me to do this?" "No, I'm okay." You know they always made sure you were not overwhelmed yourself, even though they were struggling and that struck me. They are such a wonderful population and people. I was just really grateful. I'm really grateful to my supervisors Dr. [Forbes] Porter and Dr. [Constantine] Stratakis allowed me to have this opportunity because we, of course, have a job here. Then they let me do something that I felt was a calling for me. They supported me. I think that's what is wonderful about NIH, how supportive most of the people are around you because they all want you to evolve. They wanted you to get published, to do research, do things you want to do. I felt like I was given opportunities especially during this pandemic to do things. They always support, for example, now I volunteer to administer COVID vaccine to the NIH employees sometimes when I have free time. I was really worried during the beginning staging of the pandemic, but as I got to know things we can do to prevent [it] and now we have the vaccine, it's been wonderful.

Barr: If given the opportunity, would you volunteer in another capacity or do another deployment?

Saidkhodjaeva: Yes. I'll totally do it, especially now. I know a lot of places need vaccine administration. Our patient load is not big, I would love to do that.

Barr: That's wonderful. Thank you very much for your service. I loved interviewing you, and I hope that you, your colleagues, and your family continue to stay healthy.

Saidkhodjaeva: Thank you.